STATE OF NEW JERSEY
DEPARTMENT OF CHILDREN AND FAMILIES

MATCH INFORMATION FORM

SAMPLE

Provider Agency: ABC Provider Agency
Address: Trenton, New Jersey

Contract Term: *July 1, 2007* to *June 30, 2008*

I. Calculation of Match

Step 1:	Insert amount of Total Operating Budget from Line H of Annex B; Official Contract Budget.			*$112,000*
Step 2:	Insert the value of any State Agency approved In-Kind Contribution.			*3,000*
Step 3:	Add amounts from Steps 1 and 2.			*115,000*
Step 4:	a.	From page 10 of Annex B-1, enter the source and the amount of all Cost Sharing other than Match.		
		(1) Medicaid Reimbursement	*17,000*	
		(2) Client Fees	*2,000*	
		(3) Ceta	*6,000*	
	b.	Add the amounts listed in Step 4a and enter this amount.		*25,000*
Step 5:	Subtract amount obtained in Step 4b from subtotal in Step 3.			*90,000*
Step 6:	Multiply the amount in Step 5 by 25% to obtain total amount of required match.			*x .25* *22,500*
Step 7:	To calculate the amount of required cash match, subtract the amount listed in Step 2 from the amount obtained in Step 6.			*3,000* *19,500*

II. Type(s), Source(s), and Amount(s) of Match

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List the source(s) and amount(s) of all match for the SSBG service Contract. For In-Kind Contributions, attach additional sheets to indicate the Budget Category to which the In-Kind applies and to justify the determined value of the In-Kind Contribution. In addition, attach all documentation as to the availability and commitment of match.

	Type	Source	Amount
A.	Cash Donations	*Division of* ----	*9,000*
		United Way	*3,000*
		Provider Agency	*7,500*
B.	In-Kind Contributions	*County* ----	*3,000*
		TOTAL MATCH	*$22,500*